DOCUMENT RESUME

ED 276 158 EC 190 910

AUTHOR	Carson, Ann Taylor
TITLE	A Professional Challenge: Working with Multi-Problem Families.
INSTITUTION	San Diego State Univ., Calif.
SPONS AGENCY	Special Education Programs (ED/OSERS), Washington, DC. Handicapped Children's Early Education Program.
PUB DATE	86
GRANT	G008302287
NOTE	49p.; A part of Project IINTACT.
AVAILABLE FROM	Project IINTACT, Special Education Department, San Diego State University, San Diego, CA 92182 ($5.00; make check payable to SDSU Foundation).
PUB TYPE	Guides - Non-Classroom Use (055)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Alcoholism; Communication Skills; *Developmental Disabilities; Drug Abuse; *Family Problems; Health; *High Risk Persons; *Home Visits; Knowledge Level; Motivation; One Parent Family; Parent Education; Self Concept; Social Isolation; *Social Problems; *Social Services; Violence; Young Children

ABSTRACT

The manual for professionals working with multi-problem families was developed by Project IINTACT which provided home-based services to families with young children who were developmentally delayed or at risk of developmental delay. Three groups of high risk families were served: those in which one or more parents is mentally retarded, those families with serious psychosocial difficulties, and families in which the mother is an unmarried minor. The manual suggests strategies for dealing with the following problems within the family: (1) poor self concept of the mother, (2) gaps in essential parenting knowledge, (3) social isolation, (4) health concerns, (5) poor communication skills, (6) lack of motivation, (7) socioeconomic problems, (8) poor nutrition, (9) family violence, and (10) alcoholism and substance abuse. Problems between the family and home visitor are also discussed and include hostility, distrust, and fear of outsiders; language and cultural differences; and non-compliance (such as missed appointments). Also noted are problems of the home visitor including turf protection against other service providers, fear about visiting families in hazardous urban areas, and professional burn-out. (DB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED276158

A PROFESSIONAL CHALLENGE:
WORKING WITH
MULTIPROBLEM FAMILIES

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Ann Carson
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

A PROFESSIONAL CHALLENGE: WORKING WITH MULTI-PROBLEM FAMILIES

Ann Taylor Carson, RN, MS, MN, NP

The development of this manual was supported by grant number G008302287 from the United States Office of Education, Office of Special Education and Rehabilitation Services, Handicapped Children's Early Education Program. The opinions expressed are those of the author and do not necessarily represent the United States Office of Education or San Diego State University.

© 1986

EC196910

acknowledgements

I would like to express my gratitude to Sue Bakley, Martha Marsden, Gail White, Mary Hammond de Cordero, and Yrma Nixon for their many valuable contributions toward the completion of this manual. These contributions emerged from many years of collective concern and caring working with multiproblem families.

Bardy Anderson did the layout for the manual and Joe Ferrara provided the illustrations.

I would especially like to thank Eleanor Lynch for her encouragement to write this manual and her continued support and editorial assistance throughout its completion.

table of contents

Introduction 1

Purpose 3

Background 4

Problems and Strategies 7

- Problems within the Family 8
- Problems between the Family and Home Visitor 31
- Problems of the Home Visitor 34

Summary 37

References 39

A PROFESSIONAL CHALLENGE:
WORKING WITH MULTI-PROBLEM FAMILIES

introduction

Project INTACT, a model demonstration project funded by the Handicapped Children's Early Education Program during 1983-1986, provided home-based services to three groups of high-risk families with young children who are developmentally delayed or are at risk of developmental

delay. These three groups are: families in which the parent/s is/are mentally retarded, multi-problem families with serious psychosocial difficulties, and families in which the mother is an unmarried minor. Home-based services were provided by two-member teams of a professional and paraprofessional in collaboration with other community agencies. The professionals included a special educator and a pediatric nurse practitioner; the paraprofessional staff were two mothers of special needs children. The parent community worker working with the multi-problem families was also bilingual in Spanish and very familiar with Hispanic culture. Working toward the goal of preventing or remediating early developmental delays in the children, these teams made concentrated efforts to provide meaningful service to these families over a two-year period.

Project staff want to share their learning about the needs of "hard to reach,""multi-problem" families --- needs which alter the approaches to service and requirements for early intervention staff.

purpose

Multi-problem families are not new to social service workers, health professionals or educators; however, little has been written to suggest practical approaches for working with these families in their homes. The purpose of this manual is to provide information about these families including both parents and children and to highlight some of the major problems these families face with some suggestions for home-based intervention for professionals and paraprofessionals. After working with a culturally and linguistically diverse group of families, Project IINTACT's interdisciplinary staff has identified several strategies and suggestions that we feel are useful in working with this challenging population. We believe these techniques are useful when working with many different types of families and are certainly not limited to multi-problem families. We encourage you to consider our approach, adopt what seems to work well in your situation and continue to try new strategies.

Because of the complex nature of multi-problem families and the many issues and situations confronting them, it is essential that professionals and paraprofessionals working with these families understand the potential impact of the interventions they use. This requires extensive training, supportive supervision, and continuing review of the literature written by experts in the field. This manual is intended only as an overview and sampler of some of the major problem areas and possible points for intervention. For fuller understanding of these complex factors in the lives of families with multiple problems, readers are strongly encouraged to consult in-depth resources such as those listed as references.

background

Multi-problem families or multi-risk-factor families as defined by Greenspan (1982) experience a broad variety of problems which create a higher risk of infant mortality, perinatal morbidity, and developmental difficulties for their children. In broad categories, these problems may be due to psychological, socioeconomic, interpersonal, crime or substance abuse-related, and social isolation factors (Greenspan, 1982; Jantzen & Harris, 1980; Morin, 1981). These families typically lack an ability to cope effectively with daily demands. Parents tend to focus on the immediate needs with little consideration given to the future or to the results of their past and present actions on the future. Often these parents think only in concrete terms.

In multi-problem families, children tend to grow up in homes in which there is little money; the parents may be unemployed and poorly educated. Only one parent may be present in the home; there may be violence between the parents or violence directed at the child. Because of limited money and knowledge of nutrition, food may be scarce and of poor quality. The children may have few toys or opportunities for intellectual stimulation; the parents often have few friends or family members to provide support or encouragement. Housing is usually very poor--crowded, in disrepair. Often families have no car or easy access to effective public transportation. For single mothers with several children, this problem has many negative consequences. For example, they are often compelled to shop in expensive, small neighborhood markets. Single mothers often do not use community resources because of the difficulty in getting to them; health care for themselves and their children is frequently neglected; their social isolation is increased. For some families, the parents have serious psychological diagnoses including psychoses and personality disorders.

Greenspan (1982) reported preliminary findings of a 2 year study of 50 multi-risk-factor families, in which the research focus was the prevention of developmental problems among the children. Subjects were given prenatal care that effectively reduced the incidence of perinatal problems and infant mortality. It was found that in the most seriously impaired families, the children experienced developmental problems within the first year of life. The children of less seriously disturbed parents often did not

purpose

Multi-problem families are not new to social service workers, health professionals or educators; however, little has been written to suggest practical approaches for working with these families in their homes. The purpose of this manual is to provide information about these families including both parents and children and to highlight some of the major problems these families face with some suggestions for home-based intervention for professionals and paraprofessionals. After working with a culturally and linguistically diverse group of families, Project IINTACT's interdisciplinary staff has identified several strategies and suggestions that we feel are useful in working with this challenging population. We believe these techniques are useful when working with many different types of families and are certainly not limited to multi-problem families. We encourage you to consider our approach, adopt what seems to work well in your situation and continue to try new strategies.

Because of the complex nature of multi-problem families and the many issues and situations confronting them, it is essential that professionals and paraprofessionals working with these families understand the potential impact of the interventions they use. This requires extensive training, supportive supervision, and continuing review of the literature written by experts in the field. This manual is intended only as an overview and sampler of some of the major problem areas and possible points for intervention. For fuller understanding of these complex factors in the lives of families with multiple problems, readers are strongly encouraged to consult in-depth resources such as those listed as references.

background

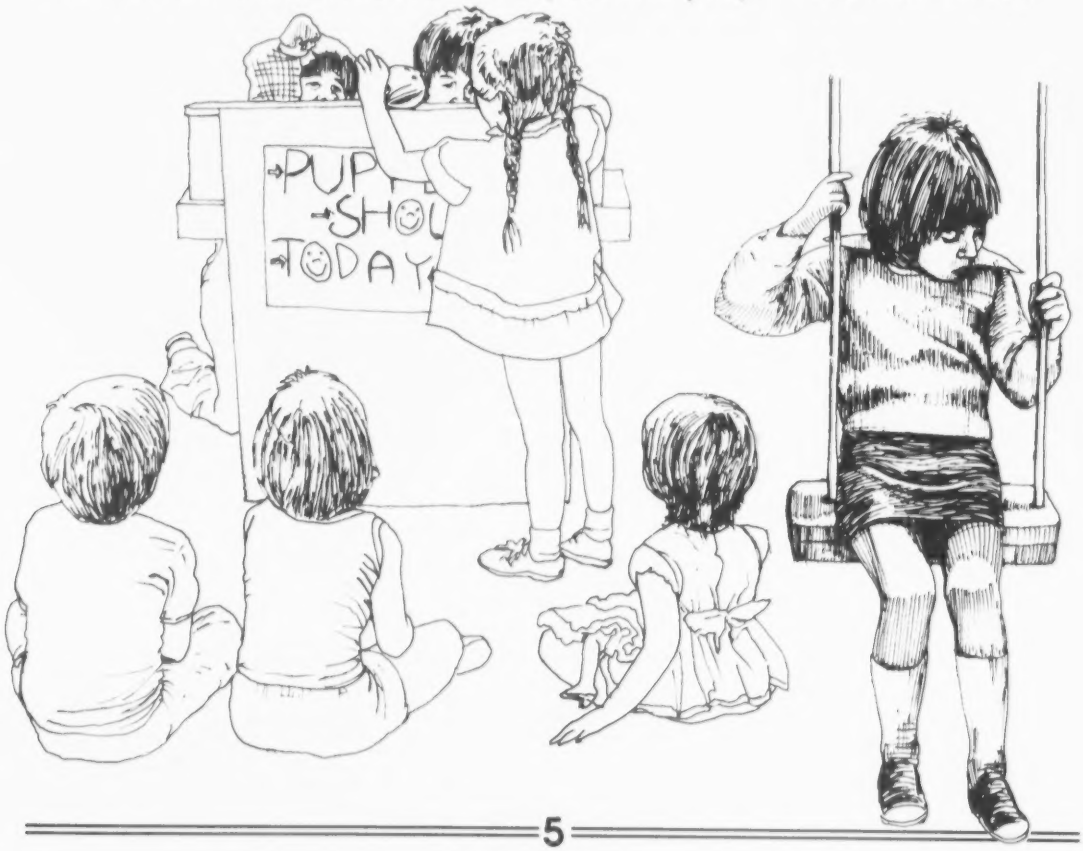
Multi-problem families or multi-risk-factor families as defined by Greenspan (1982) experience a broad variety of problems which create a higher risk of infant mortality, perinatal morbidity, and developmental difficulties for their children. In broad categories, these problems may be due to psychological, socioeconomic, interpersonal, crime or substance abuse-related, and social isolation factors (Greenspan, 1982; Jantzen & Harris, 1980; Morin, 1981). These families typically lack an ability to cope effectively with daily demands. Parents tend to focus on the immediate needs with little consideration given to the future or to the results of their past and present actions on the future. Often these parents think only in concrete terms.

In multi-problem families, children tend to grow up in homes in which there is little money; the parents may be unemployed and poorly educated. Only one parent may be present in the home; there may be violence between the parents or violence directed at the child. Because of limited money and knowledge of nutrition, food may be scarce and of poor quality. The children may have few toys or opportunities for intellectual stimulation; the parents often have few friends or family members to provide support or encouragement. Housing is usually very poor--crowded, in disrepair. Often families have no car or easy access to effective public transportation. For single mothers with several children, this problem has many negative consequences. For example, they are often compelled to shop in expensive, small neighborhood markets. Single mothers often do not use community resources because of the difficulty in getting to them; health care for themselves and their children is frequently neglected; their social isolation is increased. For some families, the parents have serious psychological diagnoses including psychoses and personality disorders.

Greenspan (1982) reported preliminary findings of a 2 year study of 50 multi-risk-factor families, in which the research focus was the prevention of developmental problems among the children. Subjects were given prenatal care that effectively reduced the incidence of perinatal problems and infant mortality. It was found that in the most seriously impaired families, the children experienced developmental problems within the first year of life. The children of less seriously disturbed parents often did not

demonstrate developmental difficulties until their second year of life. As early as 1 month of age, the highest-risk children were not demonstrating normal capacities to orient to their surroundings, to habituate, to console themselves, or to be socially responsive. By 3 months of age, the babies often had developed neither regular patterns for eating, sleeping or wakefulness, nor interest in their environment. Eye contact was poor; they tended to tense their muscles and to experience swings in mood. As the children grew older, they did not develop relationships with other people. In the cases where there was some interpersonal involvement, the relationship tended to be superficial and unemotional.

By the end of the first year of life, the children were often withdrawn and very obedient, or aggressive and impulsive in a very disorganized manner. During the children's second and third years, these developmental patterns became even more seriously impaired. These children were raised in an environment in which there was little verbal communication or symbolic play. Both of these



activities normally allow a child to begin to understand himself within the world around him. Instead these children regressed to thinking only in concrete terms during play or in communication. Often they were still very emotionally labile, unable to sort out reality, or to control their impulses. Clinically, these children might display severe mood swings, become easily frustrated or angry, be out of touch with reality for short periods of time, have difficulty discriminating right from wrong, and seemingly not care about others. They usually have difficulty developing a strong sense of self apart from others. They were often asocial or antisocial. By the end of the preschool years, the children had become like the parents.

Despite the severity and number of problems which characterized these families, skillful intervention was able to reduce developmental difficulties. Many of these children's maladaptive behaviors were remediated by careful assessment and diagnosis of the developmental difficulty, followed by an organized and comprehensive treatment approach that included specific techniques and psychosocial services. Greenspan (1982) suggested an approach that provided services to meet survival needs of the family, services to insure meeting the family's need for a trusting, long-term relationship, techniques directed at reversing or preventing specific developmental deficits, and a mechanism to provide enriched day care for the child, outreach services to the parents and continuing professional development of the staff. Because of the multifactorial nature of the potential for developmental problems, the treatment approach must be comprehensive, long-term, and highly personalized.

Other researchers (Garland, Stone, Swanson, & Woodruff, 1981) also document the efficacy of early intervention with children who have a clear diagnosis of a disability. Their findings support the value of intervention as close in time to birth as possible, since the greatest rate of learning and development occurs during the first few years of life. Efforts to promote early development yield the greatest developmental gains and forestall developmental delay. For children who are not yet clearly diagnosed with a disability, but who are known to be at risk for developmental delay, early intervention activities as described by Greenspan (1982) are vital.

Moran (1985) described a variety of programs available for families with developmentally delayed children. She found that mothers participating in home-based programs had a significantly better attitude toward their children than those in center-based programs. These mothers saw the strengths of their disabled children and were proud of their accomplishments. They were also more likely to seek the advice of many resource people about the care of their children. Greenspan (1982) found this trend in the multi-risk-factor families also as the mothers receiving comprehensive services became more nurturing and able to encourage the development of their children.

problems and strategies

Problems encountered by professional and paraprofessional home visitors working with multi-problem families can be grouped into three primary categories:

1. Problems within the family.
2. Problems between the family and home visitor.
3. Problems of the home visitor.

Specific concerns within each category will be discussed in the following sections, and strategies for addressing these issues will be presented. Again, it is important to remember that these are suggested strategies, and that each professional/paraprofessional working with multi-problem families is encouraged to use those approaches that seem most comfortable considering each individual family and the worker's own strengths.

Working with multi-problem families is exceptionally challenging and the immediate rewards in terms of improved family functioning may be minimal. Several years of intervention may be required to see real change in the family. The home visitor should feel gratified with even small steps taken by the family members toward meeting their goals. The underlying philosophy presented in this manual is that these families are worthy of community efforts to assist them to become more functional members of society and that they deserve the respect and sincere concern of professionals and paraprofessionals with whom they interact.

1 ● **POOR SELF-CONCEPT OR SELF-ESTEEM** that interferes with successful parenting is a common finding among mothers in multi-problem families. Horney (1950) believed that poor self-esteem grew out of feelings of helplessness and isolation and generated much anxiety in adulthood. Mothers with poor self-esteem question their abilities and

competence. Often the value a mother attaches to herself is a reflection of the value she thinks that others in her world attach to her. If she does not feel respected and accepted by others, she will have greater difficulty respecting and accepting herself. Self-esteem, then, is built on self-respect, respect by others, acceptance by others and self, and success in life.

The self-esteem of parents affects child-rearing practices. Leler (1981) describes several studies that document the influence of the mother's self-esteem on the child's self-esteem. Low self-esteem in the mother correlates with a diminished ability to express warmth and acceptance to her children. It has also been proposed that the mother's low self-esteem relates directly to her children's intelligence scores.

Several strategies are essential for building a successful relationship with families or individuals of low self-esteem. Egan (1986) identifies **respect** and **genuineness** as the foundations of any helping relationship. Respect is conveyed not only in attitude, but also through concrete behaviors. Placing some demands on a mother or helping her place more demands on herself may help her see that she has more potential than she is realizing. For some mothers these demands will need to be very simple and easily accomplished. This strategy also demonstrates that the home visitor is "for" the client.

Home visitors must commit themselves to families they work with and believe that the families, no matter how troubled, are worth their time and energy. Individuals within the families and the families themselves must be valued for their uniqueness and positive qualities. Home visitors need to avoid trying to mold a family into some preconceived stereotype. One difficult challenge for professional and paraprofessional helpers is to recognize that families do have the resources to manage their lives effectively.

Professionals tend to be involved with the family when these resources are blocked or unused. The home visitor's responsibility is to assist the

family in identifying these resources and finding ways to capitalize on them, but ultimately the family must decide whether and how to use internal and external resources. Respect for the client is also demonstrated by the basic assumption that the family wants to function more effectively and is willing to work toward that goal.

Genuineness can be displayed in several ways. One way is to not get caught in overemphasizing your role as a home visitor or in the ways you believe you "should" behave. It is helpful to be open, spontaneous, nondefensive, and assertive in relationships with families. Consistency between values and actions is important. Families can usually tell when you think one thing and say or do another and this can result in an insurmountable barricade to a successful relationship. Families also identify genuineness when a home visitor is willing to share something of him/herself and his/her experiences. This does not mean revealing one's life story but sharing personal experience when it seems appropriate. A home visitor who shares his/her reactions to his/her own disabled child starting school with a mother who is concerned about her young, handicapped child going off to school on the bus for the first time can reassure the mother that her feelings are natural. When the mother hears the concern and understanding of the home visitor, she may feel closer to the worker and more willing to share her other concerns.

Listen attentively to what family members say and how they say it. When they speak, try to accept what they are telling you without either judging or condoning. Be aware of your non-verbal commmunication to the family in gesture, tone of voice, touch, where and how you sit in the room. Often the relationship that develops between the family and the home visitor becomes very close. For many of these mothers, this experience may be the first time they have had a close relationship in which they have felt respected and important. They value this bond, begin to value themselves, and become better parents (Morin, 1981).

2 ● Many multi-problem families have had limited educational opportunities and have **MANY GAPS IN KNOWLEDGE** about child-rearing, growth and development, health, nutrition, safety, discipline --- many of the issues that are critical for parents. Often, this lack of knowledge is interpreted by others as poor judgment. For many parents, the judgment they **do** exercise is based on their own poor upbringing, questionable advice from others, or other sources such as television. The home visitor's role is to help families fill their knowledge gaps in important areas of childrearing and home management.

There are several factors to keep in mind about the learning needs of parents before deciding the best teaching approach. These factors include the following:

1. Parents are adult learners whose life experiences strongly influence their readiness to learn and their receptivity to new ideas.

2. Parents learn best if they can acknowledge their need to learn and if they want to learn.

3. Learning styles vary with adults just as they do with children. Some parents learn better by seeing, some by hearing, still others by doing, and many by various combinations of learning modes.

4. Cultural background influences learning.

5. Language level and jargon influence learning. Parents are often hesitant to admit that they don't understand complex terms that may be used very commonly by community helpers.

6. The motivation to learn is highest when the parents themselves perceive a need to know, not when the home visitor perceives a need for the parent to know.

7. Learning occurs most readily when the learner is in a comfortable, trusting environment.

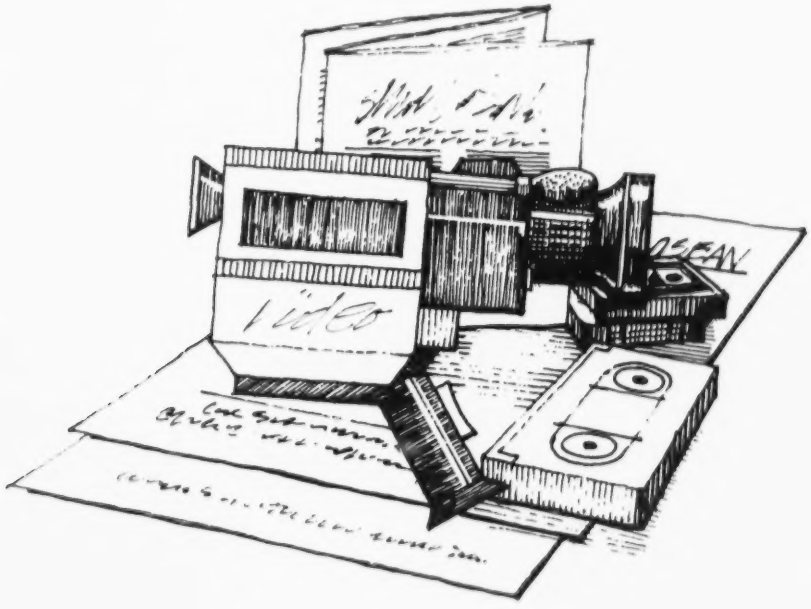
8. Learning can be cognitive (intellectual knowledge), affective (values and attitudes), or psychomotor (performance of a skill). All are equally important for effective functioning.

9. New information does not guarantee a change in behavior. For example, a helper may spend hours teaching a parent about child nutrition and dental health only to find later that the parent still feeds the child sweetened milk in a bottle at bedtime.

10. Learning occurs most readily when the parent is actively involved in the learning process --- setting goals, determining style, and evaluating the progress.

Based on these factors, several steps can be identified in the teaching/learning process. The first and perhaps most critical step is the parent's acknowledgement that the knowledge gap exists and that it is important to fill that gap. For most of us, admitting that we don't know something important is difficult to do. A useful technique may involve the use of questions to help the parent realize the deficit. This does not mean pounding the parent with a barrage of final examination questions but making a casual inquiry that still preserves the parent's dignity. Once the knowledge deficit is identified in broad terms, the specific deficits can then be

pinpointed. For example, a parent recognizes a knowledge deficit in the area of infant growth and development. What specifically does the parent already know about the developmental milestones of a 6-month-old child? If the parent understands many of those milestones but does not know how much the child should be growing at that time, then this is the specific information that should be presented. It is important to give the parent credit for pre-existing knowledge and to build on that foundation.



After setting the learning goals, the parent and home visitor need to determine the best way for the parent to learn the information. If the need is to learn a skill (e.g., how to bathe the baby), then the best approach will be demonstration by the home visitor, with practice and return demonstration by the parent. If the parent needs factual information, discussion may be the most appropriate method. Audiovisual aids such as pamphlets, cassette tapes, videotapes, or posters may be useful. If the learning goal is an attitude or value change, the critical

factor, once the information has been presented, is the parent's acceptance of that information into her own value system. This process often requires much support, encouragement and praise by the home visitor and others. Attitude and value change is a most difficult goal to achieve, as anyone knows who has ever attempted to lose weight or improve their fitness level.

Once the best learning methods have been determined, the actual teaching should be provided sequentially and at an appropriate pace. Manageable bits of information should be presented at one time, followed by feedback from the parent to assure that s/he understands what was being taught. The pacing of the presentation of the information is also important. For example, the home visitor may be feel that it is critical for the parent to know all about infant safety by the beginning of the next week. The parent, on the other hand, has many other concerns at the same time and would prefer learning about safety issues for about half of the weekly home visit time. Continuity can still be maintained in the presentation of the material as can the mother's desire to go at a slower pace. The important point is to include the mother in the decision-making and to acknowledge and respect her needs and wishes.

After presenting the new information, the home visitor should assist the parent to evaluate the newly-gained knowledge. Ideally, this monitoring has been occurring throughout the learning process to assure that the parent was understanding and assimilating. At this completion point, however, a more definitive evaluation is necessary. The format could be question-and-answer, a summary discussion, demonstration of a new skill, or acknowledgment of a new attitude or behavior. At this time, positive reinforcement and praise from the home visitor are especially helpful. New learning goals can then be identified and the process begins all over again.

3 ● SOCIAL ISOLATION is a common difficulty for families with multiple problems. Single mothers often live alone with their children and apart from family and friends. Unless they have jobs, single mothers tend to lead socially isolated lives. Even when they do work outside the home, income is usually very limited. For single mothers at home, being poor is the rule rather than the exception. Multi-problem families frequently do not use outside babysitters because of cost, unwillingness to

leave their children, or no knowledge of possible sitters. Mothers feel compelled to stay home with their children and do not seek outside community activities.

Two-parent families can also be very isolated, especially if they are poor. Perhaps they are unemployed or new to the community. In many areas of the country, there is an increasing number of non-English speaking families who are socially isolated because of the language barrier, cultural differences, unemployment and its resultant poverty, and fear of detection and deportation if they have entered the country illegally.

There are several strategies to help a family become more involved with the community and less isolated. The relationship with the home visitor is a beginning step. Even though the contact is within the client's home, the client is building a support system that is outside the family constellation. For those families in which the parent feels isolated even within the family system, helping the parents to build family unity, identity and solidarity can strenghthen the sense of family support. If roles are unclear, perhaps between a teenage mother and her own mother, taking some time to negotiate and clarify the responsibilities of each can enhance each person's sense of self and importance to the family group. For families in which the mother's existing support comes solely from the children, it is critical that the home visitor assist the mother in finding peer support and in redirecting the child to assume the role of a child in the family, not a substitute adult/parent (Jantzen & Harris, 1980). These are not easy tasks. When the worker finds that his/her support and interventions are not helping the family to become less socially isolated, the problem may be of a more serious emotional nature and referral to a local mental health professional would be indicated. The home visitor, however, can assist most families to reduce their isolation.

When the family has few contacts outside the home, the home visitor can work with the parent to identify activities that would be enjoyable and beneficial. Perhaps a mother would like to attend a parenting class but doesn't know where to find one,

what it would cost, or who would care for the children while she attended. The worker, familiar with community agencies, should be able to make an appropriate referral. In some instances, it may be necessary to transport the mother to the agency initially to begin service, to encourage participation and to build trust. The worker should then assist the mother to find her own means of transportation so that she will feel independent and competent in meeting her own needs. It is vital that the parent makes a commitment to participate. If the parent doubts the value, is too fearful, or feels the required effort is too great, s/he will not follow through with the activity.

To make an effective referral, the home visitor must work with agency representatives to explain carefully the situation and needs of the family. For many families, this process may require ongoing case conferences so that services are not duplicated, full of gaps, or inappropriate. Whenever possible, family members should be active participants in planning and implementing services. The problem of fragmented service so common among agencies certainly impacts families. Families who are receiving services from multiple community agencies may also suffer "home visitor overload" and feel resentful and hassled. Efforts to coordinate services are essential and worth the work. It is important to gain feedback periodically from the agencies and the family regarding those techniques that are working and those that need to be modified.

Another strategy to help counteract family isolation is working with the family to develop a plan to reduce the problem. A mother may not need referral to an outside agency, but she may need some time by herself or time with friends without the children. Perhaps she could trade babysitting with a neighbor, negotiate babysitting time with her husband or mother, or find a way to take the baby with her for a daily walk to the park. Try to simplify the problem by starting at home to identify existing strengths and resources that the parent(s) haven't previously considered. This will require some brainstorming, flexibility, creativity, and lots of encouragement.

4 ● **HEALTH CONCERNS** are often ignored by multi-risk-factor families for several different reasons. The family may have no health insurance or Medicaid benefits and no extra cash to pay the bill.

They may not recognize the seriousness of the health problem or may be afraid to seek care. They may not know where to go for treatment or who would be a good provider of care. They may rely on lay people for advice and treatment; there may be cultural barriers to seeking professional assistance. **LACK OF MEDICAL CARE** is a very serious concern for multi-problem families, and the difficulty is increasing as Medicaid benefits are cut back and private charitable health organizations are unable to fill the gap. Many of these families also tend to be present-oriented rather than future-oriented. Because of multiple, ongoing stresses in their lives, their motivation is more to "get by" than to plan ahead. Health problems are dealt with only when they reach crisis proportions. Only when the toddler's teeth are decayed to the gum line and he is crying in pain will the child be taken to the dentist.

In such situations, the home visitor must assist the family to modify these inappropriate, crisis-oriented health practices. Family members should be encouraged to seek care routinely to prevent the crisis or serious problem from occurring in the first place. Often, the parent may only need sound information to make the right decision. Spend some time discussing when it is appropriate to go to the doctor, dentist, or other health practitioner and how to find and use health care resources.

If the reason for neglected care is lack of money or knowledge of a care provider, the home visitor should help identify and refer the family to a provider who may be more appropriate. Perhaps the family is eligible for Medicaid but has never applied. Support and assist the family to obtain services for which they qualify. Steady encouragement and reminders are often necessary. Consider making the first appointment for the mother and transporting the family to the provider's office. Compliment the mother and reinforce appropriate actions taken by her so that she feels competent in caring for her child or herself and motivated to continue good health behaviors in the future.

5 ● COMMUNICATION is a frequent area of difficulty for multi-problem families. Often verbal communication is limited and non-verbal communication is misinterpreted. Within the family communication patterns may be ineffective and even destructive.

The home visitor must listen attentively to each family member in a non-judgmental manner and recognize that each person's comments are important.

Family members should be allowed to speak without interruption and the worker may want to make this point clear at the start of each visit.

It may be useful to feed back to the client what the home visitor hears being said so that misunderstanding will be minimized. This technique also allows the speaker to hear what he or she said in a slightly different way and challenge him or her to a new thought.

If one family member is obviously silent, the home visitor may want to draw that person out by specifically asking how they feel or what they are thinking.

Each person should be encouraged to communicate with other family members in expressing his or her own thoughts, needs, and feelings. Accusations, blame, and open hostility should not be encouraged, but should be addressed as barriers to effective communication.

An assertive communication style should be suggested and modeled by the home visitor.

For many single-parent families, communication is limited because the mother spends so much of her time alone with the children and she may rely primarily on nonverbal communication with them. This can have serious consequences for the children in terms of language delays. If the children do not have opportunities to experience spoken language, they will not develop it appropriately.

If this is a concern, the home visitor should discuss

with the mother the importance of stimulation for the child, teach the mother some techniques for promoting language development, and model good verbal interactions with the infant or child.

Encourage the mother to read to the child, to teach nursery rhymes, to sing, to imitate sounds, and to respond positively and with praise to the child's appropriate verbal requests.

Educational television programs such as "Sesame Street" and "Mr. Rogers' Neighborhood" can stimulate language acquisition for a young child as well.

In some families, the parents may misinterpret nonverbal communication. A child's fussiness may be interpreted by the parent as rejection when in truth the child is coming down with an infection or may just be tired. At times, the parents may project their own feelings onto the child and justify those feelings by the gestures and outward appearance of the child.

A worker should be sensitive to this possibility and explore with the parent any interpretations that have been made about the child's non-verbal communication. The worker may want to suggest some other possibilities and certainly explain in a non-judgmental way what is normal behavior for children. Should the misinterpretation occur between adults in the household, the worker would encourage each adult to verbalize their impressions and to "check them out" with the other person.

6 ● LACK OF MOTIVATION is often a problem ascribed to families with many problems. The feelings of helplessness and hopelessness that many families have preclude motivation to change or to believe that change is possible. Life has been hard, lonely, and poor for so long, perhaps generations, that expending the energy to do things differently, to believe that independence and competence are possible seems beyond their grasp. Some families, no doubt, may be comfortable with their present lifestyle since it is all they have known and they are content to live day to day. They may resist outside influences encouraging them to go to school or work or to change.

The home visitor usually will not be able to motivate these families, but s/he can assist them to identify their own goals and develop strategies to attain them. If the family's goal is to maintain the status quo, the home visitor can offer encouragement and other alternatives, but s/he cannot make the needed changes.

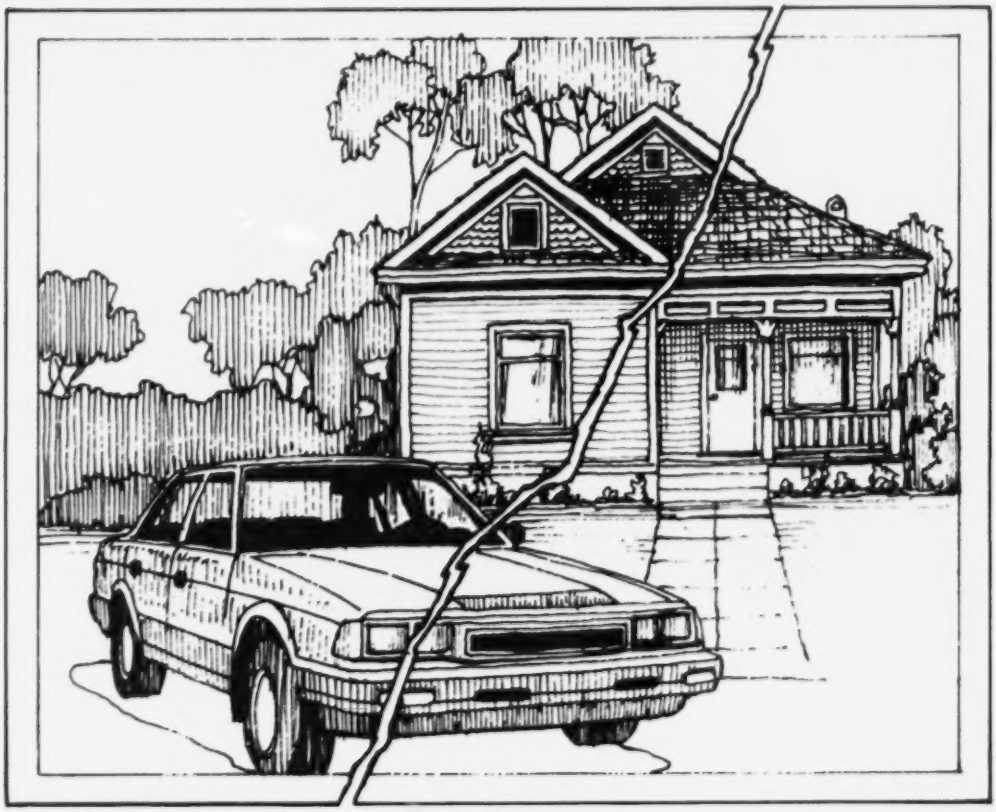
For families in which the missing motivation to change is due to temporary depression, poor self-concept, or lack of insight about available resources, the home visitor can make important contributions. Again, the first step is to help the family identify long and short-term goals. Once they have been listed, concrete measures to indicate accomplishment of those goals with a time-frame and personal responsibility for their completion should be outlined. This process should be done as concretely as possible, preferably in writing, and with as much family commitment as possible. Strategies to enhance self-concept, as discussed earlier, can be used here if necessary. Acknowledge each small step in the change process. Praise the family for new insights and behaviors that lead toward the accomplishment of their goals. Assist the families to use resources through referral, support and encouragement. As the family sees barriers dimimish, the motivation to keep going will be enhanced. Success encourages ongoing efforts and belief that change is possible.

7 ● SOCIOECONOMIC PROBLEMS are almost universal for multi-problem families. These include substandard and crowded housing, low income, unemployment, lack of transportation, a dangerous environment for children, victimization by crime, increased exposure to public health hazards (poor sanitation, carriers of diseases, increased disease), and limited supplies, clothing, food, toys, and equipment for care of the children.

While the home visitor cannot provide the job, the money, the new house, or the material needs of the family, what s/he can do is to use referral and networking processes to assist the family in using all available community resources. These can include Section VIII housing (from the Department of Housing and Urban Development); Aid to Families with Dependent Children (AFDC); Medicaid; the local unemployment office for job training and referral; low cost stores for child care supplies; and public or private agencies that may loan or rent equipment, provide food, or offer other services. Each community has resources available to help meet many of the unmet needs of multi-problem families. Often local churches are a good place to start. The worker must learn how to find and use the community resources to help families in need.

In working with young mothers who may have dropped out of school to have their babies, it is important to encourage them to return to school to complete their education. Many school districts now have programs to accommodate these students and their children. With a high school diploma, these young women are better prepared to care for their children independently and to have a higher standard of living. Child care programs may be available within the community to parents who are in training, looking for work, or working. These programs often have extended hours to accommodate the needs of working parents, and the cost is minimal. At the same time the parent has quality child care, the child has an opportunity for socialization and much new learning.

The home visitor can also assist the family to be assertive in exploring avenues to improve substan-



dard housing and environmental hazards. Referral to appropriate official agencies, legal aid, or the public health department may be beneficial. If the family is in the country illegally, the home visitor must be sensitive to the various community agencies' policies with regard to eligibility for service and reporting to law enforcement.

The worker can assist the family in identifying employment choices and encouraging a mother to pursue a job when that is appropriate. This strategy, however, can be effective only to the extent that the mother is really interested in working outside the home. A home visitor who imposes his/her own work values on a mother who does not share them will probably harm the relationship she has cultivated with the mother.

8 ● POOR NUTRITION is another serious problem for the children and parents in multi-risk-factor families. Poor nutrition may be the result of limited access to foods because of economic constraints, poor health habits, or lack of knowledge about proper nutrition. These children are often undernourished even though they appear chubby or healthy. They do not have to be thin in appearance. Anemia is common because of inadequate iron intake. Dental problems are common because of bottle mouth syndrome or lack of daily fluoride supplements. Many children consume large quantities of junk foods because the parents like them, they are easy to prepare and readily available. Many families with limited budgets try to provide the highest quality foods possible; however, because of the high cost of meats, fruits and vegetables, carbohydrates often become the major component of the diet. Many of the programs (e.g., Food Stamps, WIC, and school breakfast and lunch programs) designed to improve nutrition for children now have tighter eligibility requirements so that fewer and fewer families are benefitting from this assistance.

What then are some strategies for working with families to improve their nutritional status? The first step is to ascertain the reasons for the poor nutrition. A 24-hour diet diary or log is very helpful to determine diet deficiencies as well as to use as a teaching tool for explaining the components of a good daily diet. Each family member should keep a diet log for several days and include all snacks, regular meals and vitamin supplements. If the reason appears to be a lack of knowledge about good nutrition, then the family should be presented with the appropriate information. If the home visitor does not feel competent in this area, s/he can use other community resources and written materials. Public health nurses, dieticians from local hospitals, and staff from health organizations may be available to help. If the nutritional difficulty seems to be in the parent's preferences and habits, then the home visitor's job becomes more challenging. Again, information about nutrition and child growth and development is usually helpful. Parents usually want the best for their children and will make changes accordingly, even though they may not modify their own health practices. The primary goal is to

encourage the parents to promote good health and normal growth and development in the child.

When the nutrition problem is primarily due to financial constraints, the parents should be encouraged to apply for public assistance, such as AFDC and food stamps, as appropriate. Additionally, the WIC

program provides coupons to low income women who are pregnant, have infants, or, in some cases, have young children. WIC covers limited itens such as formula, dairy foods, and cereals. Many communities have food co-op programs in which families can participate by contributing a modest amount of time and money each month for a substantial amount of food. Churches often have emergency supplies of food to assist families with an immediate need. Again, the home visitor needs to keep aware of resources available in the local area.

There may be occasions when the home visitor arrives to find that there is no food in the house. This seems to happen on Friday afternoons when there is not time to contact community agencies. Often the worker is tempted to give the family money to buy enough food for the weekend. This is an individual decision that only the home visitor can make; however, should the home visitor decide to assist this way, it is advisable to purchase the food and deliver that rather than the cash. Should this be a recurrent situation, the children's needs should be considered as top priority and an immediate referral to the child protection agency in the area would be warranted. While giving the family money to meet the immediate need is a generous act, it can have detrimental long-term consequences. For the family, it may mean that someone will always bail them out when they have a problem. Dependency can quickly become a more serious concern. The family also is saved from having to assume responsibility for meeting its own needs. Over the long run, this dependency on others can be demoralizing to family members and reinforces their feelings of helplessness. Worker goals are to assist the family to find and utilize its own internal and external resources, to assume self-responsibility, and to feel competent and worthwhile. Activities should reflect these goals.

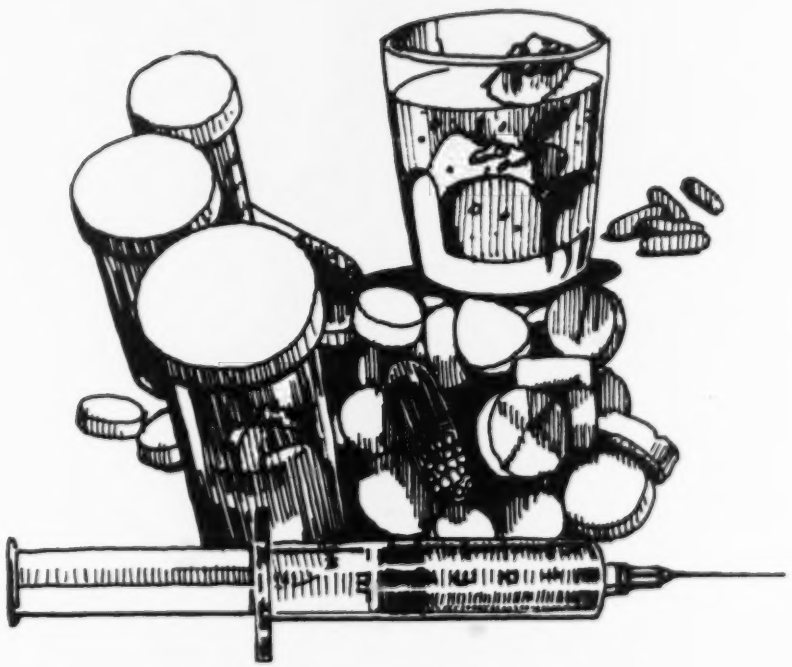
9 ● For some multi-problem families **FAMILY VIOLENCE** is a fact of life. Professional and paraprofessional helpers must be able to understand the dynamics of family violence and convey empathy toward the abused wife who may find it difficult, for various reasons, to leave an abusive relationship. This is an important area for ongoing inservice for professional and paraprofessional staff.

The home visitor's role is to offer support to the abused partner, encourage her to care for herself and her children, and help her to find shelter and other resources as she expresses these needs. Because her self-esteem is severely compromised, the abused wife benefits a great deal from demonstrations of respect, support, and empathy from the home visitor and activities to improve her sense of competence and worth. If the children are at risk of abuse or neglect or have been abused/neglected, the worker is required by law to contact the police or the child protection agency in the area. Because of the complex nature of family violence, the worker should refer the family to a mental health professional and continue to provide emotional support and encouragement to the family. Many communities have support groups to assist abused as well as abusive parents.

10 ● **ALCOHOLISM AND SUBSTANCE ABUSE** are also concerns of many multi-problem families.

The home visitor's role is limited in this area because of the complexity of the problem and the home visitor's primary goal of facilitating the growth and development of the children. A major first step may be just the identification of the problem and its acknowledgement by family members. Parents are reluctant to admit that substance abuse and/or alcoholism is affecting their daily lives and abilities to function. Family members should be encouraged to seek assistance from professionals, hospitals, and community organizations to resolve the substance abuse problem. Referrals to appropriate support groups (e.g., Alcoholics Anonymous, Alanon, etc.) should be given. The children need to be assessed

for the effects of substance abuse, since some parents may be sharing drugs and alcohol with them. Discussions and materials regarding the use of drugs, alcohol and even prescribed medications may be helpful for those families who have some motivation to change harmful patterns of chemical use. While the improved functioning of the family is a major goal, the safety of the children is paramount, and the home visitor needs to direct his/her activities with that in mind. If the safety of the children is in jeopardy, for example, because the mother is drunk each morning, a referral to the local child protection agency is indicated.



=problems between the family and home visitor=

1 ● Professional and paraprofessional helpers who work in the home with multi-problem families almost always are faced with some **HOSTILITY, DISTRUST, AND FEAR OF OUTSIDERS** from family members. These negative attitudes may be the result, in part, of prior unpleasant experiences with insensitive workers or representatives of law enforcement or child protective agencies who were perceived as punitive by the family. To overcome this hostility, fear or distrust requires great patience and sensitivity with the family by the worker.

Trust can be built by showing respect and genuineness as discussed previously. Follow through by home visitors in doing what they say they'll do is most important. One valuable strategy is to bring a promised item the next time the worker comes to the home. Families see this as a concrete example of trustworthiness. The time required to build trust may seem endless, but consistent concern and persistence by the worker will be effective in ultimately establishing a good relationship with the family.

The worker must demonstrate to the family that s/he is "for" the family. Respect and genuineness are certainly essential; however, it is also important to minimize any social class distinctions such as an expensive car s/he may drive or elegant clothing s/he may wear. A simple, well-groomed appearance is probably the most appropriate for the home visitor to present and model for the family.

As the relationship between the home visitor and the parents, especially the mother, grows stronger, clients may begin to imitate in some way the behavior, appearance, or attitude of the worker. This situation presents a potent opportunity for the home visitor to facilitate positive change, as long as it is based on underlying respect for the family's own values.

2 ● LANGUAGE AND CULTURAL DIFFERENCES of agency staff and clients are serious concerns that present a constant challenge for effective service delivery. Human service agencies must attempt to hire staff members who represent the culture and ethnicity of the community they serve. If it is not possible to hire enough staff who are culturally similar to clients, then experienced translators, inservice education programs, and other activities must be used so that service delivery will be compatible with the cultural beliefs and practices of ethnic groups served by the agency.

The importance of sensitivity to cultural beliefs and practices cannot be overemphasized. A major blunder in this area can totally eliminate successful intervention with a family. For example, some cultures view our American habit of summoning someone by crooking the index finger as a behavior appropriate only for animals. If these family members were summoned in such a manner by the home visitor, they would certainly not feel respected and could become hostile and uncooperative. Each cultural group deserves to be treated with an understanding of their background and respect for their particular beliefs.

In those cases where family childrearing and health practices are culturally appropriate but inappropriate based on current knowledge or law, the home visitor needs to help the family recognize that some behavior changes may be necessary. An example of this is the Southeast Asian practice of "coining." This process must be done with great care, sensitivity, and explanation, when appropriate, about American legal requirements. The family should be given the opportunity to explain their own beliefs and to discuss their feelings about necessary changes.

3 ● NON-COMPLIANCE, including **MISSED APPOINTMENTS** with the home visitor, is often a problem with multi-problem families. The underlying reason for a client to fail to comply with a plan or to keep an appointment is that she has a different set of priorities from those of the home visitor. Unless the parent and the home visitor share the same goals, means of achieving the goals, and priorities, it is unlikely that the parent will

follow through with suggestions made by the worker or keep appointments.

To help the family improve its patterns of poor compliance, the home visitor can develop mutually agreed goals and contracts with the family. Initially this means determining the family's basic willingness and desire to receive service. Families have the option to refuse services not part of a court order. Once the family's interest in receiving service has been affirmed, the home visitor must assess the values and priorities of the family and use them as the starting point for an action plan. If the goals of the plan reflect only the worker's values, it will surely fail. Families act in accord with their values, needs and priorities at a given time. What may have been a priority last week may not be important this week, and the family will not follow through with an appointment or assigned task related to the "old" priority. This seemingly unpredictable behavior of problem families is usually very frustrating for professional and paraprofessional helpers. When non-compliance or missed appointments occur, the home visitor should discuss with the family its changing priorities and needs and develop with them a new plan which addresses their current situation.

If the home visitor becomes angry or upset with the family for missing an appointment or failing to follow through on an action, this anger may eventually damage the relationship and the effectiveness of the intervention efforts. In-service to assist workers to deal with their anger and frustration is important and should be a priority of agencies working with multi-problem families. By realizing that families act in accord with their own values and needs, this anger can be redirected to developing a current, acceptable plan. The worker should not assume personal responsibility for the "non-compliant" behaviors nor should s/he assume that the family does not like the worker.

problems of the home visitor

1 ● Inter-agency protection of one's **TURF** can become a problem for home visitors who interact with personnel from other community agencies. These families frequently receive service from several community resources, and each worker may want to be that family's primary interventionist. This leads to fragmentation of services and much confusion for the family.

It is essential that all professionals and paraprofessionals working with a family have regular case conferences to coordinate services for their mutual families. One person may assume the role of case manager with agreement by the others to facilitate the mechanics of the process.

During the case conference, it is important for all members to understand the role and goals of each of the others and to discuss their combined impact on the family.

If it appears that duplication of service is occurring, negotiation should resolve who will assume primary responsibility for the duplicated service.

If it appears that workers have conflicting goals or are giving the family conflicting information, the group should come to agreement about the unified approach that will be implemented. It is important to the credibility of all workers and to the welfare of the family that services be coordinated and complementary.

When possible, joint home visits by two or three workers from varying agencies can demonstrate to the family that there is unified concern and cooperation with the family.

2 ● Because of the poor socioeconomic status of these families, many of them live in **MORE HAZARDOUS AREAS** of the city. The worker may be concerned about entering a neighborhood to make the home visit.

Certainly, every precaution that would be taken in a dangerous area should be taken.

follow through with suggestions made by the worker or keep appointments.

To help the family improve its patterns of poor compliance, the home visitor can develop mutually agreed goals and contracts with the family. Initially this means determining the family's basic willingness and desire to receive service. Families have the option to refuse services not part of a court order. Once the family's interest in receiving service has been affirmed, the home visitor must assess the values and priorities of the family and use them as the starting point for an action plan. If the goals of the plan reflect only the worker's values, it will surely fail. Families act in accord with their values, needs and priorities at a given time. What may have been a priority last week may not be important this week, and the family will not follow through with an appointment or assigned task related to the "old" priority. This seemingly unpredictable behavior of problem families is usually very frustrating for professional and paraprofessional helpers. When non-compliance or missed appointments occur, the home visitor should discuss with the family its changing priorities and needs and develop with them a new plan which addresses their current situation.

If the home visitor becomes angry or upset with the family for missing an appointment or failing to follow through on an action, this anger may eventually damage the relationship and the effectiveness of the intervention efforts. In-service to assist workers to deal with their anger and frustration is important and should be a priority of agencies working with multi-problem families. By realizing that families act in accord with their own values and needs, this anger can be redirected to developing a current, acceptable plan. The worker should not assume personal responsibility for the "non-compliant" behaviors nor should s/he assume that the family does not like the worker.

problems of the home visitor

1 ● Inter-agency protection of one's **TURF** can become a problem for home visitors who interact with personnel from other community agencies. These families frequently receive service from several community resources, and each worker may want to be that family's primary interventionist. This leads to fragmentation of services and much confusion for the family.

It is essential that all professionals and paraprofessionals working with a family have regular case conferences to coordinate services for their mutual families. One person may assume the role of case manager with agreement by the others to facilitate the mechanics of the process.

During the case conference, it is important for all members to understand the role and goals of each of the others and to discuss their combined impact on the family.

If it appears that duplication of service is occurring, negotiation should resolve who will assume primary responsibility for the duplicated service.

If it appears that workers have conflicting goals or are giving the family conflicting information, the group should come to agreement about the unified approach that will be implemented. It is important to the credibility of all workers and to the welfare of the family that services be coordinated and complementary.

When possible, joint home visits by two or three workers from varying agencies can demonstrate to the family that there is unified concern and cooperation with the family.

2 ● Because of the poor socioeconomic status of these families, many of them live in **MORE HAZARDOUS AREAS** of the city. The worker may be concerned about entering a neighborhood to make the home visit.

Certainly, every precaution that would be taken in a dangerous area should be taken.

Cars should be locked and valuables should not be visible. It is important to park as close to the family's front door as possible.

If the home visitor sees people or dogs in the yard or street close by that worry her/him, s/he may prefer to not stop at that time, but rather go to a telephone, call the client and reschedule the visit.

If the client (e.g., the mother) with whom the worker had an appointment is not home, but another person is present and states that the client is expected to return shortly, the worker must decide whether to remain in the home, reschedule the appointment, or wait in the car for the client's return. The home visitor must always be alert to issues of personal safety.

A self-defense class is a wise precaution for all home visitors. Often two workers visiting a family together minimizes worker concerns about personal safety. At no time should a home visitor jeopardize his/her safety.

3 ● People who work with multi-problem families face **BURN-OUT** as a consequence. Each person will experience burn-out at different times and in different ways. For many workers burn-out causes a decline in sensitivity to families, physical exhaustion, and cynicism.

It is essential that workers acknowledge these feelings and take steps to re-energize themselves. Often this means taking time out in the form of a vacation or a change in work duties. For the home visitor whose families rely on their services consistently, perhaps the key is to build into the job description a variety of activities. When the only task is working with families, the rate of burn-out is increased. By rotating other tasks or allowing for a variety of responsibilities, the rate is slowed. It is also important for the worker to consider his/her expectations and sources of satisfaction. Often the home visitor must learn to gain satisfaction from the small steps families take in changing.

The home visitor needs a support system at work that encourages the appropriate expression of the worker's feelings and frustrations about the families. Whether this support comes individually from coworkers or in a group setting designed to allow venting and emotional support for all workers, it is necessary to plan this opportunity to prevent burn-out.

Flexible work schedules that allow home visitors extra "time out" during the day or week can be very helpful. Workers must understand the dynamics of stress, its early warning signs and implications, and techniques for stress reduction. For those workers who think that burn-out is a sign of weakness or failure, try to remember that burn-out occurs only to those who care a great deal and become intensely involved with the people they serve. Caring and involvement can be maintained without burn-out if efforts are made to remediate stress, build a support system, and take "time out."

summary

Working with multi-problem families poses daily challenges. Problems within the family seem never-ending. The scope of these problems requires the home visitor to be knowledgable in many areas. To some degree, the worker must be a "jack of all trades" including nurse, educator, social worker, and therapist as well as a friend. Competence as a home visitor with these families is developed with training, sensitivity, and experience. Expectations of rapid change in the family will probably lead to disappointment and frustration. Small steps taken by families should be viewed as successes both for the family and the worker. Each should take pride in the progress and continue in the efforts to change step by step. With the foundations of respect and genuineness, the helping relationship has its greatest potential for success.

Problems that develop within the relationship can also concern the home visitor. These include hostility and distrust of the family for outsiders, language and cultural differences, and the family's "non-compliance" with the contracted activities. While it is not always possible to overcome all of these problems, mutual respect and understanding by both the family and the worker for each other may allow many of these difficulties to be sufficiently managed so that an effective relationship may develop.

Workers often feel frustrated by small gains made by families and by the tremendous amount of time these families require. Multiple agencies are usually involved and the home visitor must collaborate with each of the other workers involved with the family as well as with the family itself. The home visitor may feel overwhelmed by his/her concerns about safety, turf, and ultimately, his/her fitness for working with multi-problem families as he/she begins to experience burn-out. If the worker can recognize the strengths of the family, the strengths of the relationship with the family, and his/her own strengths, he/she will be taking a major step toward finding a measure of satisfaction in working with these families. Even though the effort seems unending and overwhelming at times, seeing the children grow and develop normally makes the work worthwhile.

references

Egan, G. (1986). The skilled helper. Monterey, CA: Brooks/Cole Publishing Co.

Garland, C., Stone, N.W., Swanson, J., & Woodruff, G. (Eds.). (1981). Early intervention for children with special needs and their families: findings and recommendations. WESTAR Series Paper No. 11. Seattle, WA: The University of Washington, Seattle.

Greenspan, S.I. (1982). Developmental morbidity in infants in multi-risk-factor families: clinical perspectives. Public Health Reports, 97(1), 16-23.

Horney, K. (1950). Neurosis and human growth. New York: W.W. Norton & Co., Inc.

Jantzen, C. & Harris, O. (1980). Family treatment in social work practice. Itasca, IL: F.E. Peacock Publishers, Inc.

Leler, H. (1981). Program approaches designed to enhance parental strengths and self-concepts. In M. Bryce & J.C. Lloyd (Eds.), Treating Families in the Home (pp. 237-248). Springfield, IL: Charles C. Thomas.

Moran, M.A. (1985). Families in early intervention: effects of program variables. Zero to Three, 5(5), 11-14.

Morin, P. (1981). The extended family model: increasing service effectiveness. In M. Bryce & J.C. Lloyd (Eds.), Treating Families in the Home (pp. 135-146). Springfield, IL: Charles C. Thomas.